Commonwealth Coordinated Care (CCC) Phase-Out Plan

Stakeholder Feedback

Introduction

Section III.L.4 of the CCC Memorandum of Understanding (MOU) requires that, prior to terminating the demonstration, DMAS must submit a draft phase-out plan to CMS. Prior to submitting the draft phase-out plan, DMAS must publish on its website the draft phase-out plan for a 30-day public comment period. DMAS shall summarize comments received and share this summary with CMS. Once the phase-out plan is approved by CMS, the phase-out activities must begin within 14 days.

This document provides detail on the proposed phase-out plan and transition to the Commonwealth Coordinated Care Plus (CCC Plus) program developed by CMS and DMAS. Please review and submit comments to the CCC mailbox (ccc@dmas.virginia.gov).

Please note that the phase-out plan is not intended to include detailed instructions to health plans regarding closing out their operations (for example, reporting requirements, responsibility for pending appeals, etc.); CMS/DMAS will provide that information to the plans separately.

CCC Plus Overview

DMAS, with support from the Governor and the General Assembly, is implementing a new managed long term services and supports initiative, known as CCC Plus. CCC Plus will operate statewide across six regions as a mandatory Medicaid managed care program, and will serve approximately 216,000 individuals (adults and children) with disabilities and complex care needs. More than half of the CCC Plus participants are dually eligible for Medicare and Medicaid and many individuals (dual and non-dual) receive care through nursing facilities or through one of the DMAS home and community based services waivers. Individuals receiving services through the Developmental Disabilities waivers will be enrolled in CCC Plus for their non-waiver services only at this time.

CCC Plus will launch by region beginning in the Tidewater region on August 1, 2017. CCC Plus members will have access to an individualized, person-centered system of care that integrates medical, behavioral, and long term care services and supports. Members will have a dedicated care coordinator who will work with the member and their provider(s) to ensure timely access to high-quality care.

DMAS has statewide contracts with six (6) health plans to operate CCC Plus. These health plans are: Aetna Better Health of Virginia; Optima Health Community Care; Anthem HealthKeepers Plus; UnitedHealthcare Community Plan; Magellan Complete Care of Virginia; and, Virginia Premier Health Plan.

Individuals who are awaiting CCC Plus program assignment or who are not eligible to participate in CCC Plus (or another DMAS managed care program) will continue to be covered through the DMAS fee-for-service program. In addition, some services are carved-out of the CCC Plus managed care contract and will continue to be covered through fee-for-service. These are described at a high-level in the table

below. Detailed information on CCC Plus included and excluded populations, carved-out services, and the CCC Plus regional implementation schedule are available on the CCC Plus webpage at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

CCC Plus Excluded Populations	CCC Plus Carved Out Services
1. Limited Coverage Groups (Family Planning, Governor's Access Plan, Individuals with Medicare who do not have full Medicaid benefits, i.e., QMB only) 2. Intermediate Care Facilities for Individuals with Intellectual or Developmental Disabilities (ICF/IID) 3. Certain Nursing Facilities (NF), including the Veterans NFs, Government owned NFs, The Virginia Home, State owned NFs. 4. Psychiatric Residential Treatment Level C 5. Alzheimer's Assisted Living Waiver 6. Money Follows the Person (MFP) 7. Hospice (CCC Plus enrolled individuals who elect hospice will remain in CCC Plus) 8. PACE – coverage continues through the PACE provider. 9. Medallion 3.0 and FAMIS MCO enrolled individuals; coverage continues through the MCO 10. Individuals enrolled in the Health Insurance Premium Payment Program (HIPP) 11. CCC enrolled individuals, until the CCC demonstration program ends.	1. DD Waiver Services, including waiver related transportation services, until after the completion of the ID/DD redesign 2. Dental care through the Smiles for Children Program 3. School Health Services required as part of the child's individualized education program (IEP) 4. Community Intellectual Disability Case Management 5. Individuals and Families Developmental Disability Services Support Coordination. 6. Preadmission Screening Services 7. Community mental health rehabilitation services (CMHRS) until 12/31/2017
Individuals who are not eligible to participate in CCC Plus or another managed care program will continue to receive services through fee-for-service.	*Carved-out services are paid through fee-for-service for CCC Plus enrolled individuals. Some of these services may be included in CCC Plus at a later time*

Content of Phase-Out Plan

A. Beneficiary Transitions –

1. Medicaid beneficiary assignment and coverage options:
   For Medicaid coverage, members who are enrolled in a CCC health plan that has also contracted with the state as a CCC Plus health plans will transition from the CCC plan to the CCC Plus plan without a break in services. These members will be notified of the transition and their ability to select a different CCC Plus health plan roughly 30 days prior to this transition (December 1, 2017). They will have an additional 90 days (until

March 31, 2018) from the start of their CCC Plus coverage to select a different CCC Plus health plan. These members will have their first open enrollment period October 1, 2018, which is six (6) months after their last option to switch plans.

CCC members who are enrolled in a CCC health plan that is NOT also contracted with the state as a CCC Plus health plan will be assigned to a CCC Plus health plan using an intelligent assignment algorithm. This algorithm has been designed to minimize the disruption of services as much as possible by assigning members to MCO's contracted with the members 'priority' provider(s) (Nursing facility, Adult Day, or HCBS providers). These members will be notified of the transition and their ability to select a different CCC Plus health plan 30 days prior to this transition (December 1, 2017). They will have an additional 90 days (until March 31, 2018) from the start of their CCC Plus coverage to select a different CCC Plus health plan. These members will have their first open enrollment period October 1, 2018, which is six (6) months after their last option to switch plans.

The chart below is provided for additional clarity on the assignment and coverage options:

Health Plan	Default Medicaid assignment	Other options for Medicaid coverage	How member exercises choice
VA Premier CCC enrollees	*Virginia Premier Health Plan (CCC Plus)*	*Another CCC Plus Health Plan*	*Member will be notified of their options by the State prior to transition. Member can receive education on and assistance with selecting another plan using our enrollment broker.*
Anthem HealthKeepers CCC enrollees	*Anthem HealthKeepers Plus (CCC Plus)*	*Another CCC Plus Health Plan*	Member will be notified of their options by the State prior to transition. Member can receive education on and assistance with selecting another plan using our enrollment broker.
Humana CCC enrollees	*A CCC Plus health plan contracted with the members 'priority*	*Another CCC Plus Health Plan*	Member will be notified of their options by the State prior to transition.

	providers' to minimize disruption in services.		Member can receive education on and assistance with selecting another plan using our enrollment broker.

2. Medicare beneficiary assignment and coverage options:
   For Medicare coverage, CCC enrollees will have the option to enroll in a managed care plan under Medicare Advantage (MA) or elect Medicare fee-for-service and a standalone Part D Prescription Drug Plan (PDP). As part of CCC Plus, participating organizations are required to operate a MA Dual-Eligible Special Needs Plan (D-SNP), thereby offering an opportunity for dual eligible members to receive care coordination with a corresponding MLTSS plan.

   In an effort to promote continuity of care for dual-eligible beneficiaries currently enrolled in the CCC demonstration, CMS may allow for certain enrollees to be passively enrolled from their current CCC health plan into their MA parent organization's D-SNP product, subject to certain conditions. Conditions include ensuring that the CCC health plan and D-SNP have substantially similar provider and facility networks; that the organization's D-SNP and MLTSS plan provides substantially similar or enhanced Medicare and Medicaid benefits; that beneficiaries will not be subject to an MA premium or increases in Medicare cost-sharing; and that the overall D-SNP capitated payment rate is limited to the CY 2018 Medicare FFS risk-adjusted county rate. Enrollees who are passively enrolled will have the option to enroll in alternative Medicare coverage options, including a different MA plan or Original Medicare with a Part D plan.

   For individuals that are not passively enrolled, the default Medicare assignment will be Original Medicare with a standalone Part D plan, unless the individuals chooses another Medicare options (i.e., MA plan).

   CMS anticipates making a final determination of which CCC health plans and D-SNPs will be eligible for passive enrollment by early Fall 2017. Members will receive notification about their 2018 Medicare plan assignment and options in October 2017.

Group	Default Medicare Assignment	Other options for Medicare coverage	How member exercises choice
VA Premier and Anthem Healthkeepers CCC members in counties meeting CMS/DMAS specified passive enrollment criteria	*D-SNP affiliated with enrollee's CCC health plan*	*Original Medicare with Part D plan or other Medicare Advantage plan (including D-SNPs)*	*Members will be notified of their Medicare enrollment options. If members do not take action by December 31, 2017, they will be automatically enrolled into the D-SNP*

			affiliated with their current CCC health plan, with coverage starting January 1, 2018. *Members that want to enroll in a different Medicare Advantage plan (including D-SNPs) or instead enroll in Original Medicare can call 1-800-MEDICARE (TTY users should call 1-877-486-2048) or visit Medicare.gov.*
VA Premier and Anthem Healthkeepers CCC health plan members in counties NOT meeting CMS/DMAS specified passive enrollment criteria	*Original Medicare with Part D plan. Those not selecting Part D prior to Jan 1 will be in LINET and then assigned to a Part D Plan.*	*Medicare Advantage plan*	*Members will be notified of their Medicare enrollment options. If members do not take action by December 31, 2017, they will be automatically enrolled into Original Medicare with a Part D plan, with coverage starting January 1, 2018.* *Members that want to enroll in a Medicare Advantage plan (including D-SNPs) can call 1-800-MEDICARE (TTY users should call 1-877-486-2048) or visit Medicare.gov.*
Humana MMP members	*Original Medicare with Part D plan. Those not selecting Part D prior to Jan 1 will be in LINET and then assigned to a Part D Plan.*	*Medicare Advantage plan*	*Members will be notified of their Medicare enrollment options. If members do not take action by December 31, 2017, they will be automatically enrolled*

			into Original Medicare with a Part D plan, with coverage starting January 1, 2018. *Members that want to enroll in a Medicare Advantage plan (including D-SNPs) can call 1-800-MEDICARE (TTY users should call 1-877-486-2048) or visit Medicare.gov.*

3. Continuity of Care:
   For Medicaid, all participating CCC Plus health plans are required to honor all existing service authorizations until the authorizations end or 90 days after the beneficiary's date of CCC Plus enrollment, whichever is sooner. At that time, most providers will need to contract with health plans in order to serve members in the MLTSS program. This 90 day continuity of care period also serves to provide additional time for providers to finalize credentialing and contracting with the plans.

   Following this 90 day continuity of care period, health plans have the option of transitioning the individual to a provider in their network, or continuing to pay out of network. For individuals who reside in a nursing facility that has not contracted with the individual's health plan, the individual will not have to transition to a new nursing facility provider. The health plan will continue out of network reimbursement to the nursing facility provider in these circumstances.

   For Medicare, all beneficiaries will have Medicare's standard Part D continuity of care protections for prescription drugs (i.e., temporary fills of non-formulary drugs during a transition period).

B. Enrollment functions -

1. Responsibilities:
   Enrollment into CCC Plus is required for eligible populations. CCC Plus enrollment will be handled by an independent enrollment broker, MAXIMUS, also known as the CCC Plus Helpline. The CCC Plus Helpline will provide information about CCC Plus to eligible members and process health plan enrollment requests received via telephone, website and mail. The CCC Plus Helpline hours of operation are Monday through Friday 8:30am to 6pm. Members or their authorized representative may call the Helpline at 1-844-374-9159. The CCC Plus enrollment website is available at: cccplusva.com. Members will be able to enroll and disenroll via the web site 24 hours per day seven (7) days a week.

Maximus will serve as the member's support system for all Medicaid enrollment and disenrollment (including from one health plan and move to another) and also provide unbiased choice counseling as described in 42 CFR 438.2 and 438.71.

Additionally, DMAS has worked with the Virginia Insurance Counseling and Assistance Program (VICAP) regarding the members Medicare delivery options. VICAP will provide individual insurance counseling assistance to individuals regarding their options when transitioning from the CCC health plan to a D-SNP, Original Medicare, or another MA plan. VICAP can be reached at: 1-800-552-3402.

Members will be able to select their Medicare coverage through the normal Medicare enrollment routes, including calling 1-800-MEDICARE, going to Medicare.gov, or directly contacting plans or an insurance agent.

2. Enrollment Timeline:
   For Medicaid, the transition from CCC to CCC Plus will occur January 1, 2018. Anthem HealthKeepers and Virginia Premier will have up to November 2017 to meet the requirements for passive enrollment. Requirements for passive enrollment are determined on a region-by-region basis, as such, plans may qualify for some, but not all, of the regions in which they currently operate as a CCC health plan. To date DMAS anticipates both Anthem HealthKeepers and Virginia Premier will meet the requirements for passive enrollment.

   For Medicare, DMAS and CMS will finalize which plans and counties have met the requirements for passive enrollment from CCC health plans into D-SNPs. Requirements for passive enrollment are determined on a county-by-county basis, and as such, plans may qualify for some, but not all, of the counties in which their MMP is currently active. Plans will be informed of which counties (if any) qualify for passive enrollment and the steps for completing both the passive enrollment notification and enrollment process by early Fall 2017. New Medicare coverage will take effect January 1, 2018.

C. Beneficiary Communications –

1. Sequence of Notices:
   DMAS is proposing that an initial notice be sent in September informing the member that their CCC coverage is ending and providing a summary of the transition plan. We believe this will give the member time to assess their options prior to open enrollment. The next letter informing them of the plan they've been assigned to would be sent at the end of November. The final letter confirming their choice will be sent at the end of December. Please see the proposed timeline below and provide suggestions to the CCC mailbox (ccc@dmas.virginia.gov).

Timeline for Medicaid Notices

- **September 2017:** DMAS sends an initial notice informing members about the transition from CCC to CCC Plus.
- **Late November 2017:** DMAS sends members a letter containing their initial assignment into a CCC Plus plan. DMAS provides information about other available health plans and resources for members to learn more about CCC Plus.
- **Late December 2017:** DMAS sends a final notice confirming CCC Plus health plan enrollment.
- **January 1, 2018:** Enrollment in CCC Plus health plan is effective.

Timeline for Medicare Notices

- **Early October 2017:** CCC health plans send a notice informing all members that their current health plan will not be offered in 2018. This notice describes options for individuals to choose their new Medicare and Part D prescription drug coverage. This notice also describes what their default Medicare enrollment will be if they do not take action to enroll in new Medicare coverage by December 31, 2017, including whether they will be passively enrolled into a D-SNP.
- **Late October 2017:** Members that will be enrolled in Original Medicare (as their default enrollment option) will receive a notice informing them of the Medicare Part D Low Income Subsidy (LIS) reassignment process and new enrollment.
- **Late October 2017:** Members that will be passively enrolled into a D-SNP will receive a 60 day enrollment notice.
- **Early December 2017:** Members that will be passively enrolled into a D-SNP will receive a 30 day enrollment notice.
- **January 1, 2018:** Enrollment in new Medicare coverage is effective.

2. Content of Notices:
   DMAS and CMS have been in communication regarding the content of the notices to be sent to the impacted members. At a minimum the Medicaid notices sent in November and December will contain: the health plan comparison chart, health plan comparison chart brochure, CCC Plus brochure, health plan assignment notice letter and one-page letter on D-SNP's. Examples of these materials can be seen at: https://www.cccplusva.com/member-materials

   Additionally, in accordance with Section III.L.4.c of the CCC MOU, all notices will include all applicable beneficiary appeal rights under Medicaid rules, including rights pertaining to changes in covered services that result from the transition to CCC Plus.

   Please review these materials and send suggestions on what content should be included in notices sent to members transitioning from CCC to CCC Plus to the CCC mailbox (ccc@dmas.virginia.gov).

3. Identification of sources of help and referrals:
   DMAS has worked with our partners to develop several paths for members to get assistance during the transition period:
   - Maximus is DMAS' contracted enrollment broker. Maximus will serve as the member's support system for all enrollment and disenrollment (including from one health plan and move to another) needs. Maximus will also provide unbiased choice counseling as described in 42 CFR 438.2 and 438.71. Maximus contact information will be included in all notices to members.

- DMAS has partnered with the state ombudsman to provide unbiased assistance to members to aid them understand their rights. The Ombudsmen are advocates with varied areas of advocacy experience and expertise in health and human services delivery (e.g., behavioral health, disability services, language and cultural diversity skills), promoting access to broad range of services and supports for the beneficiary population, and a robust resource base of knowledge and expertise in problem-solving strategies. DMAS has and will continue to engage the Ombudsman to ensure they are aware of the transition plan and fully equipped to continue in their role.
- VICAP assistance will be available to all members for their Medicare questions. DMAS has and will continue to engage VICAP staff to ensure they are aware of the transition plan and fully equipped to continue in their role. VICAP contact information has been included in communications to all duals eligible for the MLTSS program.
- The CCC health plans and CCC Plus health plans have been kept aware of the transition plan and DMAS' expectations for their role. It is expected that the MMPs will stay in contact with their members, answer any appropriate questions and refer them to Maximus for choice counseling and enrollment services.

4. Training schedule for beneficiary supports:
   DMAS has developed an extensive outreach and education program for our MLTSS initiative which includes information regarding the transition of the financial alignment demonstration members. This initiative includes one-on-one education and training meetings, ad hoc email and phone Q&A, and participation in our ongoing stakeholder advisory committee for our VICAP and Ombudsman partners. Since the transition plan is not complete we have only introduced the topic but have committed to further meetings with them to ensure they can successfully support beneficiaries as they transition.

   DMAS has required through our contract with our enrollment broker, Maximus, that all phone scripts, web content and other educational materials must be approved by DMAS staff prior to implementation. This includes any communications and materials regarding the transition of members from a MMP to MLTSS MCO. To this point we have met with Maximus on several occasions and have introduced the topic of the transition. We have committed to further meetings with them to ensure they can successfully support beneficiaries as they transition.

5. Customer Service Scripts:
   Scripts are not available at this time. DMAS, in consultation with CMS, is in the process of developing scripts for CCC enrollees contacting Maximus and 1-800-Medicare regarding their transfer to CCC Plus. Scripts will be completed prior to the September notice being sent to CCC enrollees.

6. Public information strategy:
   The phase-out plan is required to include an assessment of specific population segments that will need concentrated messaging and strategies for reaching them. Such population segments could include: people with disabilities, tribal notifications, rural areas, regions with high concentrations of affected beneficiaries, beneficiaries in institutions, etc.

   As all CCC enrollees fall into one of the groupings noted above and all are what DMAS would consider a high-risk/high-touch population we have developed our public information strategy assuming all enrollees will require concentrated messaging. As the transition rolls out DMAS will work with the Ombudsman and VICAP to identify any specific populations that may require concentrated messaging and will respond accordingly.

   One exception is that DMAS is required by federal rule to send notification to all federally recognized tribes when terminating a Medicaid program. Notification must be sent at least 60 days prior to the conclusion of the program and allow for a 30 day comment period. In accordance with this requirement DMAS will send the Paumunkey tribe notification by at least November 1, 2017.

D. Stakeholder engagement –

1. Strategy for ongoing stakeholder engagement –
   DMAS is committed to ongoing stakeholder engagement in regards to members transitioning from CCC to CCC Plus. Beginning in July, DMAS will host separate member and provider conference calls. In these calls DMAS will present any new and pertinent information and allow ample time for Q&A from the participants. DMAS will continue to host these call until demand runs out.

   Additionally, the CCC stakeholder advisory committee is transitioning to the CCC Plus advisory committee and the majority of members have agreed to continue their service. These quarterly meetings provide an opportunity for DMAS to present new and pertinent information to the members, which generally are provider associations. DMAS has already introduced the topic of the transition and will continue to provide updates as they become available. DMAS has enjoyed CMS participation in these meetings and welcomes continued participation to aid in the presentation of the transition plan.